

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>001142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/09/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE KNOLL ASSISTED LIVING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>607 WILSON CREEK RD</b> <b>LAWRENCEBURG, IN 47025</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 10-5-11.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on 10-5-11 to the Investigation of Complaint IN00093566 completed on 8-1-11.</p> <p>Survey date: November 9, 2011</p> <p>Facility number: 001142 Provider number: 001142 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN, TC Janie Faulkner, RN Cheryl Fielden, RN Jill Ross, RN</p> <p>Census bed type: Other: 17 Total: 17</p> <p>Census payor type: Other: 17 Total: 17</p> <p>Sample: 5</p> <p>Pine Knoll Assisted Living Center was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed on November 17, 2011 by Bev Faulkner, RN</p>	{R 000}			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1